BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
MICHAEL ANDRISANI, M.D.	Case No. 10-2009-199960
Physician's and Surgeon's Certificate No. G 14769	OAH No. 2011100986
Respondent.	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on July 27, 2012.

IT IS SO ORDERED July 20, 2012.

MEDICAL BOARD OF CALIFORNIA

By: _____
Linda K. Whitney
Executive Director

KAMALA D. HARRIS
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHAEL ANDRISANI, M.D.** **3701 Calavo Drive** **Spring Valley, CA 91977** **Physician's and Surgeon's Certificate No. G14769,** Respondent.	Case No. 10-2009-199960 OAH No. 2011100986 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Complainant Linda K. Whitney (Complainant) is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Abraham M. Levy, Deputy Attorney General.

2. Respondent Michael Andrisani, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Frank, Esq., whose address is 1010 Second Avenue, Suite 2500, San Diego, CA 92101.

JURISDICTION

3. On or about May 23, 1968, the Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. G14769 to respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 10-2009-199960 and will expire on December 31, 2013, unless renewed.

4. On September 14, 2011, Accusation No. 10-2009-199960 was filed against respondent before the Board. A true and correct copy of Accusation No. 10-2009-199960 and true and correct copies of all other statutorily required documents were properly served on respondent on September 14, 2011. Respondent timely filed his Notice of Defense contesting Accusation No. 10-2009-199960. A true and correct copy of Accusation No. 10-2009-199960 is attached hereto as Exhibit A and is incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 10-2009-199960. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in Accusation No. 10-2009-199960; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent does not contest that, at an administrative hearing, complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 10-2009-199960, and that he has thereby subjected his Physician's and Surgeon's Certificate No. G14769 to disciplinary action.

9. Respondent further agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. G14769, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 10-2009-199960 shall be deemed true, correct and fully admitted by respondent for purposes of any such proceeding or any other licensing proceeding involving respondent in the State of California or elsewhere.

10. Respondent understands that by signing this stipulation he enables the Board to issue a disciplinary order accepting the surrender of his Physician's and Surgeon's Certificate No. G14769 without further process.

CONTINGENCY

11. This Stipulated Surrender of License and Disciplinary Order shall be subject to approval of the Executive Director on behalf of the Medical Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for her consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

12. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Executive Director on behalf of the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and agrees that in deciding whether or not to

approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Executive Director on behalf of the Board does not, in her discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, respondent will assert no claim that the Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

13. This Stipulated Surrender of License and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

14. The parties agree that facsimile copies of this Stipulated Surrender of License and Disciplinary Order, including facsimile signatures of the parties, may be used in lieu of original documents and signatures and, further, that facsimile copies shall have the same force and effect as originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree the Executive Director of the Medical Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order on behalf of the Board:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G14769, issued to respondent Michael Andrisani, M.D., is surrendered and accepted by the Medical Board of California.

1. The surrender of Respondent's Physician's and Surgeon's Certificate No. G14769, and the acceptance of the surrendered license by the Board, shall constitute the imposition of discipline against respondent. This stipulation constitutes a record of the discipline and shall become a part of respondent's license history with the Medical Board of California.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of this Decision and Disciplinary Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of this Decision and Disciplinary Order.

4. If respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 10-2009-199960 shall be deemed to be true, correct and fully admitted by respondent when the Board determines whether to grant or deny the petition.

5. If respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation No. 10-2009-199960 shall be deemed to be true, correct, and fully admitted by respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorney, Robert W. Frank, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. G14769. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Disciplinary Order of the Medical Board of California.

DATED: 6-2-12

MICHAEL ANDRISANI, M.D,
Respondent

I have read and fully discussed with respondent MICHAEL ANDRISANI, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 6-8-12

ROBERT W. FRANK, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 6-14-12

Respectfully submitted,

KAMALA D. HARRIS
ATTORNEY GENERAL OF CALIFORNIA
THOMAS S. LAZAR
SUPERVISING DEPUTY ATTORNEY GENERAL

ABRAHAM M. LEVY
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 10-2009-199960

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **MICHAEL ANDRISANI, M.D.** **3701 Calavo Drive** **Spring Valley, CA 91977** **Physician's and Surgeon's Certificate No. G14769** Respondent.	Case No. 10-2009-199960 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Linda K. Whitney (hereinafter "Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about May 23, 1968, the Medical Board of California issued Physician's and Surgeon's Certificate Number G14769 to MICHAEL ANDRISANI, M.D. (hereinafter "Respondent"). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded, or have such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality[1] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, §§2000, et. seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

6. Section 2242 of the Code reads as follows;

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

"(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

"(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

"(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

"(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

"(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients

constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

8. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that respondent was grossly negligent in his care and treatment of patients A.P., V.G., J.A., M.D.A., and M.A., and in his ordering, prescribing and dispensing opiates, as more particularly alleged hereinafter:

Patient A.P.

A. On or about November 16, 2005, patient A.P., then a 36-year old female, was first seen by respondent for complaints of left leg pain with numbness which had been going on for approximately six months. Patient A.P.'s medical history included a spinal cord injury three years earlier, ruptured cervical disc, and lumbar spine surgery in or about 2002. Patient A.P. was evaluated and the diagnoses of left L5 neuropathy[2] and lumbar post laminectomy syndrome were made. Respondent's history and physical examination was incomplete, lack details, and illegible. In or about the remainder of 2005, respondent treated patient A.P. with Hydrocodone APAP (Vicodin),[3] and his plan was for the patient to have physical therapy and neurology consultation. Respondent's clinical notes for 2005 were, for the most part, illegible.

B. In 2006, respondent continued to treat patient A.P. for multiple medical conditions including L5 neuropathy and fibromyalgia,[4] and he prescribed multiple pain medications including Oxycodone,[5] Percocet,[6] and Demerol.[7] During his interview with the

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[2] Neuropathy is a disorder that occurs when nerves are damaged.

[3] "Vicodin," a brand name for acetaminophen and hydrocodone bitartrate' is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[4] Fibromyalgia is one of a group of chronic pain disorders that affect connective tissues, including the muscles, ligaments, and tendons. It is a chronic pain disorder with unknown etiology and unclear pathophysiology.

[5] "Oxycontin," a brand name for oxycodone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug (continued...)

Medical Board investigator, respondent stated that patient A.P. had requested the Demerol. Respondent also prescribed Lyrica,[8] Xanax,[9] and Cymbalta,[10] and on or about November 21, 2006, patient was placed on a trial of Dilaudid[11] which the patient found not helpful. Respondent's clinical notes for 2006 were, for the most part, illegible.

C. In early 2007, respondent changed patient A.P.'s Dilaudid to Norco[12] at the patient's request, and referred her to outpatient rehabilitation for back and neck pain. Respondent continued to prescribe Norco, Percocet, and Morphine,[13] and began to provide patient A.P. with Demerol injections. In October, 2007, patient A.P. was referred for pain consultation with little relief from the epidural injections. Respondent's clinical notes for 2007 were, for the most part, illegible.

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pursuant to Business and Professions Code section 4022. is a narcotic pain reliever similar to morphine.

[6] "Percocet," is a brand name for oxycodone and acetaminophen, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[7] "Demerol, a brand name for meperedine, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[8] "Lyrica," a brand name for pregabalin, is a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-epileptic drug called anticonvulsants.

[9] "Xanax," a brand name for alprazolam, a benzodiazepine, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

[10] "Cymbalta," a brand name for duloxetine, is a dangerous drug pursuant to Business and Professions Code section 4022. It is an antidepressant.

[11] "Dilaudid," a brand name for hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[12] "Norco," a brand name for acetaminophen and hydrocodone bitartrate, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[13] Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

D. In 2008, patient A.P. continued to see respondent approximately every two weeks. On almost every visit, patient A.P. received Demerol injections. In addition, respondent continued to prescribe and/or refill the patient's Oxycontin, Hydrocodone,[14] Morphine, Valium, Xanax, and Cymbalta. Patient A.P. was also seen by a pain specialist and a neurosurgeon for lumbar radiculopathy due to lumbar stenosis. Respondent's clinical notes for 2008 were, for the most part, illegible.

E. In 2009, respondent continued to prescribe and/or refill patient A.P.'s Percocet, Hydrocodone, Opana,[15] Morphine, Oxycodone, Ambien,[16] Valium, Xanax, and Ativan[17] several times a month, and only saw the patient in his office on approximately three occasions. Respondent continued to provide patient A.P. Demerol injections during her visits. Respondent's clinical notes for 2009 were, for the most part, illegible.

F. In or about 2010, patient A.P. underwent lumbar spine surgery. Respondent continued to provide patient A.P. with Demerol injections with the last dose on or about December 27, 2010, and to prescribe and/or refill her Hydrocodone, Oxycodone, Cymbalta, Ambien, Xanax, Percocet, Morphine, and Valium. In or about February, 2010, patient A.P. was seen by Dr. D.B. at UCSD in consultation for her spinal stenosis. Dr. D.B. stated in his report that he was very concerned about patient A.P.'s post-operative pain management and that he would discuss it with respondent. In or about June, 2010, respondent added

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[14] Hydrocodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[15] "Opana," a brand name for oxymorphone hydrochloride, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[16] "Ambien," a brand name for zolpidem, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative used for the short-term treatment of insomnia.

[17] "Ativan," a brand name for Lorazepam, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It belongs to a group of drugs called benzodiazepines.

Pamelor[18] to patient A.P.'s medications, and in or about September, 2010, added Phentermine.[19] Respondent's last prescription for patient A.P. was for Percocet on or about January 4, 2011. Respondent's clinical notes for 2010 were, for the most part, illegible.

9. Respondent committed gross negligence in his care and treatment of patient A.P. which included, but was not limited to, the following:

(a) Respondent, for over three years, failed to perform periodic reviews of patient A.P.'s pain, treatment, and status.

(b) Respondent failed to follow-up with the recommendations of the specialists.

(c) Respondent failed to recognize the misuse of patient A.P.'s controlled substances.

(d) Respondent's medical records on patient A.P. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for a patient with chronic pain conditions.

(e) Respondent failed to adequately document his evaluation and treatment of patient A.P.'s complicated disease of chronic pain.

(f) Respondent failed to adequately document the purpose, risks, benefits, and goals of opioid therapy for patient A.P.

(g) Respondent initiated the use of Cymbalta, an antidepressant, on patient A.P. without a documented purpose and specific reason.

Patient V.G.

G. In or about December, 2000, respondent started treating patient V.G., then a 45-year old female, for migraine headaches, and continued treat her until in or about December 2010. Respondent's treatment consisted of, but was not limited to the following

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[18] "Pamelor," a brand name for nortriptyline, is a dangerous drug pursuant to Business and Professions Code section 4022. It is in a group of drugs called tricyclic antidepressants.

[19] Phentermine is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant and an appetite suppressant.

medications: Demerol injections, Xanax, Lortab,[20] and Imitrex.[21] In addition, patient V.G. was receiving from two other physicians, opiates, such as Methadone,[22] Lortab, Ambien, Fentanyl[23] Patch and oral Fentanyl.

H. In 2005 to 2007, respondent continued to provide patient V.G. with 100-200 mg. Demerol injections for her migraine headaches during office visits, and continued to prescribe and/or refill the patient's Xanax. In or about 2007, respondent began giving patient V.G. Vistaril[24] in combination with the Demerol. Respondent's clinical notes for 2005 to 2007 were, for the most part, illegible.

I. In 2008 and 2009, respondent continued to treat patient V.G.'s migraine headaches with 100-200 mg. Demerol injections during office visits, and continued to prescribe and/or refill the patient's Xanax. In or about April, 2008, respondent added Clonazepam[25] 1 mg. to patient V.G.'s treatment, and in or about May, 2008, added fibromyalgia[26] in his assessment of the patient. Also, in or about February, 2009, respondent added Hydrocodone to the patient's treatment, and in or about July, 2009, added

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[20] "Lortab," a brand name for hydrocodone and acetaminophen, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[21] "Imitrex," a brand name for sumatriptan, is a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat headaches.

[22] Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[23] Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

[24] "Vistaril," a brand name for hydroxyzine, is a dangerous drug pursuant to Business and Professions Code section 4022. It is used as a sedative to treat anxiety and tension.

[25] Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

[26] Fibromyalgia is a common syndrome in which a person has long-term, body-wide pain and tenderness in the joints, muscles, tendons, and other soft tissues.

Oxycodone. Respondent's clinical notes for 2008 to 2009 were, for the most part, illegible.

J. In 2010, respondent's treatment of patient V.G.'s migraine headaches remained essentially the same. He continued with 100-200 mg. Demerol injections during office visits, and prescribed and/or refilled the patient's Xanax. Respondent's clinical notes for 2010 were, for the most part, illegible.

K. During respondent's interview with the Medical Board investigator, he stated that he was not managing patient V.G.'s pain but giving her some intermittent relief. Respondent also stated that patient V.G. asked for increasing Demerol doses but that he did not document this in his notes.

10. Respondent committed gross negligence in his care and treatment of patient V.G. which included, but was not limited to, the following:

(a) Respondent's medical records on patient V.G. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for the patient with chronic pain conditions.

(b) Respondent failed to follow-up with the recommendations of the specialists.

(c) Respondent failed to recognize the misuse of patient V.G.'s controlled substances.

(d) Respondent failed to recognize that the patient was receiving opiates from other physicians.

(e) Respondent, over the years, failed to perform periodic reviews of patient V.G.'s pain, treatment, and status.

(f) Respondent failed to develop and record a treatment plan for patient V.G., or pursue discussing with the patient the benefit of continued modalities such as psychiatric behavioral counseling.

(g) Respondent failed to adequately document his evaluation and treatment of patient V.G.'s complicated disease of chronic pain.

(h) Respondent failed to adequately document the purpose, risks, benefits, and goals of opioid therapy for patient V.G.

(i) Respondent continued to treat patient V.G.'s chronic illness with long term intramuscular Demerol for years without consulting with specialty services, and without documenting the specifics of those services.

(j) Respondent treated patient V.G.'s chronic migraine headache symptoms with chronic opioid therapy without documented indications, without indication for the injectable forms of opioids, and without documented goals.

Patient J.A.

L. On or about October 31, 2005, patient J.A., then a 32-year old female, was first seen by respondent for peripheral neuropathy and degenerative disc disease of the lumbar spine. Respondent's history and physical examination was incomplete, lack details, and illegible. Respondent refilled patient J.A.'s prescriptions for 90 pills of Oxycodone 10/325, 270 pills of Methadone 10 mg., and 90 pills of Soma 350.[27] In 2005, respondent continued to prescribed and/or refill patient J.A.'s Oxycodone, Methadone, and Percocet. Respondent's clinical notes for 2005 were, for the most part, illegible.

M. On or about January 24, 2006, patient J.A. signed a Long Term Controlled Substances Therapy Contract. In 2006, respondent continued to prescribe and/or refill patient J.A.'s Methadone, Percocet, Xanax, and Soma. In May, 2006, respondent added Lyrica[28] to patient J.A.'s medication, and in or about July, 2006, switched her Percocet to Oxycontin. In or about November, 2006, respondent noted that patient J.A. was off Methadone and he increased her Oxycontin to 80 mg. three times a day. Respondent's clinical notes for 2006 were, for the most part, illegible.

N. In 2007, respondent continued to prescribe and/or refill patient J.A.'s Oxycontin, Soma, Xanax, and Methadone. Respondent's clinical notes for 2007 were, for the most part, illegible.

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[27] "Soma," a brand name for carisoprodol, is a dangerous drug pursuant to Business and Professions Code section 4022. It is a muscle relaxant.

[28] "Lyrica," a brand name for pregabalin, is a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-epileptic drug, also called an anticonvulsant.

O. On or about January 30, 2008, respondent documented in his notes his plan to warn patient J.A. about the cardiac toxicity of Methadone. In 2008, respondent had approximately four office visits with patient J.A. but continued to prescribe and/or refill her Methadone, Xanax, and Oxycontin. On or about September 22, 2008, a Discharge Summary from G. Hospital stated that patient J.A. was "narcotic dependent." Respondent's clinical notes for 2008 were, for the most part, illegible.

P. In 2009, respondent continued to prescribe and/or refill patient J.A.'s Methadone, Soma, Xanax, and Hydrocodone. In or about July 1, 2009, respondent added Chlordiazepoxide[29] to patient J.A.'s medications. On or about September 28, 2009, respondent noted that patient J.A. needed to return to monthly office visits because of the amount of medication she was receiving, and that she would have to get her medications from someone else if she was not able to comply. Respondent's clinical notes for 2009 were, for the most part, illegible.

Q. In or about January, 2010, respondent decreased patient J.A.'s Methadone to 70 mg. per day, and then to 60 mg. per day on or about March 4, 2010. On or about March 29, 2010, respondent increased the dose of Methadone to 90 mg. per day. In 2010, respondent continued to prescribe and/or refill patient J.A.'s Methadone, Hydrocodone, Xanax, and Soma. On or about July 22, 2010, patient J.A. signed a Patient Treatment Contract, and respondent noted that patient J.A. was "very resistant to med change." On or about August 4, 2010, respondent terminated his patient relationship with patient J.A., noting that there was a breakdown in trust between them. On or about August 17, 2010, respondent provided patient J.A. prescriptions for Methadone and Hydrocodone. Respondent's clinical notes for 2010 were, for the most part, illegible. During respondent's interview with the Medical Board investigator, he stated that he did not routinely dispense opiates other than

[29] Chlordiazepoxide hydrochloride is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is the prototype for the benzodiazepine compounds.

Tramadol[30] samples.

11. Respondent committed gross negligence in his care and treatment of patient J.A. which included, but was not limited to, the following:

(a) Respondent failed to develop and record a treatment plan for patient J.A., or pursue discussing with the patient the benefit of modalities such as psychiatric behavioral counseling and physical therapy.

(b) Respondent, over the years, failed to perform periodic reviews of patients J.A.'s pain, treatment, and status.

(c) Respondent failed to have patient J.A. establish care with pain management, neurology, and psychiatry.

(d) Respondent failed to recognize the misuse of the patient's controlled substances and that she was receiving opiates from other physicians.

(e) Respondent's medical records on patient J.A. are illegible and cursory.

(f) Respondent failed to document standard guidelines in the use of controlled substances for the patient with chronic pain conditions.

(g) Respondent failed to adequately document his evaluation and treatment of patient J.A.'s complicated disease of chronic pain.

(h) Respondent failed to adequately document the purpose, risks, benefits, and goals of patient J.A.'s opioid therapy.

(i) Respondent utilized adjuvant medication such as anti-anxiety drugs, and tricyclic anti-depressants without indication, and without specific documented reason.

Patient M.D.A.

R. On or about May, 1999, patient M.D.A., then a 44-year old female, was first seen by respondent after she had fallen down a stairs, and continued to treat her until on or about June 30, 2010. In or about January, 2001, respondent diagnosed patient M.D.A. with

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[30] Tramadol is a dangerous drug pursuant to Business and Professions Code section 4022. It is a narcotic-like pain reliever.

a lumbo-sacral strain, and began prescribing Lortab 10/500 four times a day for L5 neuropathy and cervical spine strain.

S. In 2005, respondent saw patient M.D.A. approximately four times in his office but continued to prescribed and/or refill patient M.D.A.'s Lortab and Hydrocodone the entire year. On or about October 6, 2005, respondent requested a pain consultation for patient M.D.A. Respondent's clinical notes for 2005 were, for the most part, illegible.

T. In 2006, respondent saw patient M.D.A. in his office approximately two times but continued to prescribe and/or refill patient M.D.A.'s Lortab and Hydrocodone. Patient M.D.A. was seen on or about January 17, 2006, and then on or about August 21, 2006. Respondent continued to prescribe hydrocodone for the six months between office visits. Respondent's clinical notes for 2006 were, for the most part, illegible.

U. On or about January 17, 2007, respondent began prescribing patient M.D.A. Demerol 100 mg. to be taken every 3 hours as needed for pain. The following day, respondent changed the Demerol to Dilaudid. In addition, respondent continued to prescribe and/or refill patient M.D.A.'s Hydrocodone. Respondent's clinical notes for 2007 were, for the most part, illegible.

V. In 2008, respondent continued to prescribe and/or refill patient M.D.A.'s Hydrocodone and Lortab. In or about April, 2008, respondent's assessment included fibromyalgia. Respondent's clinical notes for 2008 were, for the most part, illegible.

W. In 2009 and 2010, respondent continued to prescribe and/or refill patient M.D.A.'s Hydrocodone and Lortab, and in or about December, 2009, respondent added Cymbalta to patient M.D.A.'s medications. On or about June 30, 2010, patient M.D.A. signed a Long Term Controlled Substance Therapy Contract and a Patient Treatment Contract. Respondent's clinical notes for 2009 were, for the most part, illegible.

12. Respondent committed gross negligence in his care and treatment of patient M.D.A. which included, but was not limited to, the following:

(a) Respondent failed to develop and record a treatment plan, and to achieve the objectives of treatment for chronic pain and psychological conditions for patient M.D.A.

(b) Respondent, over the years, failed to perform periodic reviews of patient M.D.A.'s pain, treatment, and status, and failed to consider and provide other therapeutic modalities.

(c) Respondent failed to have patient M.D.A. establish care with pain management, neurology, physical therapy, and psychiatry.

(d) Respondent failed for years to recognize the misuse of the patient's controlled substances.

(e) Respondent approved early and numerous refills for controlled substances without providing periodic history and examination.

(f) Respondent prescribed without a clear medical indication.

(g) Respondent failed to adequately document his evaluation and treatment of patient M.D.A.'s complicated disease of chronic pain.

(h) Respondent failed to adequately document the purpose, risks, benefits, and goals of patient M.D.A.'s opioid therapy.

Patient M.A.

X. On or about March 11, 1986, patient M.A., then a 21-year old female, started treating with respondent for multiple medical conditions including interstitial cystitis.[31] Respondent continued to treat patient M.A. until in or about February, 2011. On or about July 9, 2004, patient M.A. underwent a cystoscopy, hydrodistension of bladder, and urethral dilation for the diagnosis of interstitial cystitis. In or about October, 2004, respondent placed patient M.A. on Cymbalta 30 mg. and Fentanyl 25 mcg. In or about June, 2005, respondent increased the Fentanyl dose to 50 mcg. Respondent's history and physical examination was incomplete, lack details, and illegible. Respondent's clinical notes for 2003, 2004, and 2005 were, for the most part, illegible.

Y. In 2006, respondent continued to see patient M.A., and prescribed and/or refilled her Vicodin and Fentanyl Patch. During his interview with the Medical Board

[31] Interstitial cystitis is a painful condition due to inflammation of the tissues of the bladder wall.

investigator, respondent stated that he considered himself to be patient M.A.'s primary care and pain management physician. Respondent's clinical notes for 2006 were, for the most part, illegible.

Z. In 2007, respondent saw patient M.A. in his office on approximately one occasion: on or about May 8, 2007, but continued to prescribe and/or refill patient M.A.'s Vicodin, Fentanyl Patch, and Hydrocodone. Respondent's clinical notes for 2007 were, for the most part, illegible.

AA. In 2008, respondent continued to prescribe and/or refill patient M.A.'s Vicodin and Fentanyl Patch, while seeing the patient in his office on only two occasions: on or about February 8, 2008 and April 1, 2008. Respondent's clinical notes for 2008 were, for the most part, illegible.

BB. In or about 2009, respondent continued to prescribe and/or refill patient M.A.'s Vicodin and Fentanyl Patch while seeing the patient in his office on approximately one occasion: on or about March 6, 2009. On this day, patient M.A. signed a Long Term Controlled Substance Therapy Contract, and underwent a urine drug screen which revealed positive findings for opioids and benzodiazepines. Respondent did not comment or follow-up with patient M.A. where she was receiving benzodiazepines. Respondent's clinical notes for 2009 were, for the most part, illegible.

CC. In 2010, respondent continued to prescribe and/or refill patient M.A.'s Vicodin and Fentanyl Patch, while seeing the patient in his office on only two occasions: on or about January 25, 2010 and June 24, 2010, the patient's last office visit. Respondent continued to prescribe and/or refill patient M.A.'s Vicodin and Fentanyl Patch until in or about February 2011. Respondent's clinical notes for 2010 were, for the most part, illegible.

13. Respondent committed gross negligence in his care and treatment of patient M.A. which included, but was not limited to, the following:

(a) Respondent failed to develop and record a treatment plan, and to achieve the objectives of treatment for interstitial cystitis for patient M.A.

(b) Respondent, over the years, failed to perform periodic reviews of patient

M.A.'s pain, treatment, and status, and failed to consider and provide other therapeutic modalities.

(c) Respondent's medical records on patient M.A. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for the patient with chronic pain conditions.

(d) Respondent failed to adequately document his evaluation and treatment of patient M.A.'s complicated disease of chronic pain.

(e) Respondent failed to adequately document the purpose, risks, benefits, and goals of patient M.A.'s opioid therapy.

(f) Respondent also committed gross negligence when he failed to have patient M.A. establish care with pain management and /or addiction medicine,

(g) Respondent failed, for years, to recognize the misuse of the patient's controlled substances.

(h) Respondent approved early and numerous refills for controlled substances without providing periodic history and examination and while the patient was receiving controlled substances from another provider.

(i) Respondent prescribed without a clear medical indication.

Ordering, Prescribing and Dispensing Opiates

14. During respondent's interview with the Medical Board investigator, he stated that he has never ordered Suboxone[32] although he has prescribed it. Respondent also stated that he did not have a dispensing log for narcotics and that he did not routinely dispense opiates other than Tramadol sample. However, the Automation of Reports and Consolidated Orders System (ARCOS) report shows that from on or about January 30, 2008 through October 16, 2009,

[32] "Suboxone," a brand name for buprenorphine and naloxone, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

respondent ordered, from multiple suppliers, approximately 27 bottles of Dihydrocodeine[33] products along with approximately 30 bottles of Suboxone.

15. Respondent committed gross negligence in his ordering, prescribing, and dispensing of opiates, which included, but was not limited to, the following:

(a) Respondent ordered and prescribed opiates and Suboxone but is unable to show what he did with the orders of these medications.

SECOND CAUSE FOR DISCIPLINE

(Prescribing, Dispensing or Furnishing Dangerous Drugs without Appropriate Prior Examinations and Medical Indications)

16. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2242, of the Code, in that he prescribed, dispensed, or furnished dangerous drugs to patients A.P., V.G., J.A., M.D.A., and M.A., without appropriate prior examinations and medical indications, as more particularly alleged hereinafter.

17. Paragraphs 8 through 19, above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

18. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A.P., V.G., J.A., M.D.A., and M.A., and in his ordering, prescribing and dispensing opiates, as more particularly alleged hereinafter:

19. Paragraphs 8 through 19, are hereby incorporated by reference and re-alleged as if fully set forth herein.

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[33] Dihydrocodeine is a Schedule II controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid painkiller.

20. Respondent committed repeated negligent acts in his care and treatment of patients A.P., V.G., J.A., M.D.A., and M.A., and in his ordering, prescribing and dispensing opiates which included, by not limited to, the following:

(a) Respondent, for over three years, failed to perform periodic reviews of patient A.P.'s pain, treatment, and status.

(b) Respondent failed to follow-up with the recommendations of the specialists, and failed to recognize the misuse of patient A.P.'s controlled substances.

(c) Respondent's medical records on patient A.P. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for a patient with chronic pain conditions.

(d) Respondent failed to adequately document his evaluation and treatment of patient A.P.'s complicated disease of chronic pain.

(e) Respondent failed to adequately document the purpose, risks, benefits, and goals of opioid therapy for patient A.P.

(f) Respondent initiated the use of Cymbalta, an antidepressant, on patient A.P. without a documented purpose and specific reason.

(g) Respondent failed to perform a complete initial history and physical examination on patient A.P.

(h) Respondent failed to develop and record a treatment plan for patient A.P., or pursue discussing with the patient the benefit of continued modalities such as physical therapy.

(i) Respondent's medical records on patient V.G. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for the patient with chronic pain conditions.

(j) Respondent failed to follow-up with the recommendations of the specialists, failed to recognize the misuse of patient V.G.'s controlled substances, and failed to recognize that the patient was receiving opiates from other physicians.

(k) Respondent, over the years, failed to perform periodic reviews of patients V.G.'s pain, treatment, and status, to the point that respondent stated patient V.G. requested an increase dose of Demerol.

(l) Respondent failed to develop and record a treatment plan for patient V.G., or pursue discussing with the patient the benefit of continued modalities such as psychiatric behavioral counseling.

(m) Respondent failed to adequately document his evaluation and treatment of patient V.G.'s complicated disease of chronic pain.

(n) Respondent failed to adequately document the purpose, risks, benefits, and goals of opioid therapy for patient V.G.

(o) Respondent continued to treat patient V.G.'s chronic illness with long term intramuscular Demerol for years without consulting with specialty services, and without documenting the specifics of those services.

(p) Respondent treated patient V.G.'s chronic migraine headache symptoms with chronic opioid therapy without documented indications, without indication for the injectable forms of opioids, and without documented goals.

(q) Respondent failed to perform a complete initial history and physical examination on patient V.G.

(r) Respondent treated patient V.G.'s acute migraine headache symptoms with Demerol without adequate documentation of its effectiveness, and goals of treatment.

(s) Respondent initiated and continued to utilize psychotropic drug to treat patient V.G.'s chronic pain without discussing with the patient and documenting the expected outcome, risks, benefits, alternatives, and side effects of the drug.

(t) Respondent failed to develop and record a treatment plan for patient J.A., or pursue discussing with the patient the benefit of modalities such as psychiatric behavioral counseling and physical therapy.

(u) Respondent, over the years, failed to perform periodic reviews of patients J.A.'s pain, treatment, and status, even to the point that respondent stated patient J.A. requested an increase dose of Methadone and that he gave it to her because she was crying.

(v) Respondent failed to have patient J.A. establish care with pain management, neurology, and psychiatry, and for years, failed to recognize the misuse of the patient's controlled substances and that she was receiving opiates from other physicians.

(w) Respondent's medical records on patient J.A. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for the patient with chronic pain conditions.

(x) Respondent failed to adequately document his evaluation and treatment of patient J.A.'s complicated disease of chronic pain.

(y) Respondent failed to adequately document the purpose, risks, benefits, and goals of patient J.A.'s opioid therapy.

(z) Respondent utilized adjuvant medication such as anti-anxiety drugs, and tricyclic anti-depressants without indication, and without specific documented reason.

(aa) Respondent failed to perform a complete initial history and physical examination on patient J.A.

(bb) Respondent failed to develop and record a treatment plan, and to achieve the objectives of treatment for chronic pain and psychological conditions for patient M.D.A.

(cc) Respondent, over the years, failed to perform periodic reviews of patient M.D.A.'s pain, treatment, and status, and failed to consider and provide other therapeutic modalities.

(dd) Respondent failed to have patient M.D.A. establish care with pain management, neurology, physical therapy, and psychiatry; failed for years to recognize the misuse of the patient's controlled substances; approved early and numerous refills for controlled substances without providing periodic history and examination; and prescribed without a clear medical indication.

(ee) Respondent failed to adequately document his evaluation and treatment of patient M.D.A.'s complicated disease of chronic pain.

(ff) Respondent failed to adequately document the purpose, risks, benefits, and goals of patient M.D.A.'s opioid therapy.

(gg) Respondent's medical records on patient M.D.A. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for the patient with chronic pain conditions.

(hh) Respondent failed to develop and record a treatment plan, and to achieve the objectives of treatment for interstitial cystitis for patient M.A.

(ii) Respondent, over the years, failed to perform periodic reviews of patient M.A.'s pain, treatment, and status, and failed to consider and provide other therapeutic modalities.

(jj) Respondent failed to have patient M.A. establish care with pain management and/or addiction medicine; failed, for years, to recognize the misuse of the patient's controlled substances; approved early and numerous refills for controlled substances without providing periodic history and examination, and while the patient was receiving controlled substances for another provider; and prescribed without a clear medical indication.

(kk) Respondent's medical records on patient M.A. are illegible and cursory, and he failed to document standard guidelines in the use of controlled substances for the patient with chronic pain conditions.

(ll) Respondent failed to adequately document his evaluation and treatment of patient M.A.'s complicated disease of chronic pain.

(mm) Respondent failed to adequately document the purpose, risks, benefits, and goals of patient M.A.'s opioid therapy.

(nn) Respondent failed to perform a complete initial history and physical examination on patient M.A.

(oo) Respondent ordered and prescribed opiates and Suboxone but is unable to show what he did with the orders of these medications.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

21. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that respondent failed to maintain adequate and accurate records in regards to his care and treatment of patients A.P., V.G., J.A., M.D.A., and M.A., and in his ordering, prescribing and dispensing opiates, as more particularly alleged hereinafter.

22. Paragraphs 8 through 19, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G14769, heretofore issued to respondent MICHAEL ANDRISANI, M.D.;

2. Revoking, suspending or denying approval of respondent MICHAEL ANDRISANI, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering respondent MICHAEL ANDRISANI, M.D. to pay the Board, if placed on probation, the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: September 7, 2011.

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant